

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/16/2012
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 8111 S EMERSON AVE INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of 2 (two) State complaints.</p> <p>Complaint: #IN00103513 Unsubstantiated; lack of sufficient evidence.</p> <p>Complaint: #IN00099605 Unsubstantiated; lack of sufficient evidence.</p> <p>Facility: #004972</p> <p>Date: 2-15-2012 & 2-16-2012</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>Franciscan St. Francis Health - Indianapolis is in compliance with 410 IAC 15-1.6.2, Emergency services, 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing services, Indiana State Hospital Licensure Rules.</p> <p>QA: cloughlin 03/06/12</p>	S 000			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

PHZW11

If continuation sheet 1 of 1